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Emergency Rule Filing Form

Emergency and Public Necessity rules are effective from date of filing for a period of up to 180 days.

Agency/Board/Commission:	Tennessee Department of Human Services
Division:	Medical Services
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Rule Type:
✓ Emergency Rule

Revision Type (check all that apply):
✓ Amendment
___ New
___ Repeal

Statement of Necessity:

In August 2009, approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for the new TennCare CHOICES in Long-Term Care Program was formally executed, allowing Tennessee to expand its Medicaid managed care system in order to provide eligible individuals with an integrated package of medical and long-term care benefits. This approval permits the Bureau to implement the Long-Term Care Community CHOICES Act of 2008, passed by the Tennessee General Assembly on May 20, 2008, and signed into law as Public Chapter 1190 on June 17, 2008. T.C.A. §§ 71-5-1401 et seq.

T.C.A. § 4-5-208(a)(4) permits an agency to adopt emergency rules when the agency finds that it is required by an agency of the federal government and adoption of the rules through ordinary rulemaking procedures might jeopardize the loss of a federal program or funds.

I have made a finding that the emergency adoption of amendments to Rule Chapters 1240-03-01, 1240-03-02 and 1240-03-03 is required in order to implement the Long-Term Care Community CHOICES Act of 2008 in a timely manner.

For a copy of this emergency rule, contact: Phyllis Simpson at the Department of Human Services by mail at Citizens Plaza Building, 400 Deaderick Street, 15th Floor, Nashville, Tennessee 37243-1403 or by telephone at (615) 313-4731.

_____
Virginia T. Lodge

Commissioner, Department of Human Services

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only **ONE** Rule Number/RuleTitle per row)

Chapter Number	**Chapter Title**
1240-03-01	General Rules
Rule Number	**Rule Title**
1240-03-01-.02	Definitions

Chapter Number	**Chapter Title**
1240-03-02	Coverage Groups Under Medicaid
Rule Number	**Rule Title**
1240-03-02-.02	Coverage of the Categorically Needy

Chapter Number	**Chapter Title**
1240-03-03	Technical and Financial Eligibility Requirements for Medicaid
Rule Number	**Rule Title**
1240-03-03-.02	Technical Eligibility Factors
1240-03-03-.03	Resource Limitations for Categorically Needy
1240-03-03-.04	Income Limitations for the Categorically Needy

Chapter 1240-03-01
General Rules

Amendments

Rule 1240-03-01-.02 Definitions, is amended by inserting "Bureau of TennCare", "CHOICES 217-Like Group", "CHOICES Group 1", "CHOICES Group 2", "CHOICES Member", "Enrollment Target", "Long-Term Care Program", "Medicare Savings Program", "Patient Liability", "Program of All-Inclusive Care for the Elderly (PACE)", "Statewide E/D Waiver", and "TennCare CHOICES in Long-Term Care", as new subparagraphs under paragraph (1) and by renumbering the existing subparagraphs, and by inserting new definitions for new subparagraphs (s) "Level 1 Nursing Facility care", (t) "Level 2 Nursing Facility care" and (aa) "Nursing Facility (NF)", so that as amended, paragraph (1) subparagraphs (a) through (nn) shall read as follows:

(a) Aid to Families with Dependent Children (AFDC). Refers to the name of the cash assistance program for Families and Children prior to the passage of the Welfare Reform Act in July 1996.

(b) Aid to Families with Dependent Children – Medicaid Only (AFDC-MO (Section 1931)). Refers to Section 1931 of the Social Security Act [42 U.S.C. § 1396u-1] which requires that any family group that qualifies for Medicaid based on AFDC-MO regulations prior to July 16, 1996 be tested for eligibility in this group.

(c) Bureau of TennCare (herein referred to as "TennCare" or as "Bureau"). The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers the TennCare Program. For the purposes of these rules, the Bureau of TennCare shall represent the State of Tennessee and its representatives.

(d) Caretaker relative. The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living. A Caretaker relative may be included in the AFDC-MO Category if he/she is related in the previous degrees of relationship with a child in the home who is under age eighteen (18) years of age or a child who has not attained nineteen (19) years of age and who is a full-time student in a secondary school or the equivalent and who is expected to graduate by the nineteenth birthday. [TCA § 71-3-153]

(e) Categorically Needy. Categorically Needy individuals are entitled to the broadest scope of medical assistance benefits. All recipients of Medicaid based on Section 1931-AFDC-MO and the SSI program for the aged, blind or disabled are Categorically Needy. In addition, many adults, families, pregnant women and children who do not receive cash assistance receive the Categorically Needy level of benefits for Medicaid Only assistance.

(f) CHOICES 217-Like Group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility (NF) level of care criteria, who could have been eligible for Home and Community Based Services (HCBS) under 42 C.F.R. § 435.217 had the state continued its 1915(c) HCBS Waiver for persons who are elderly and/or

physically disabled, and who need and are receiving HCBS as an alternative to NF care. This group exists only in the Grand Divisions of Tennessee where the CHOICES Program has been implemented, and participation is subject to the enrollment target for CHOICES Group 2.

(g) CHOICES Group 1. Individuals of all ages who are receiving Medicaid-reimbursed care in a NF.

(h) CHOICES Group 2. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility level of care and who qualify for TennCare either as SSI recipients or as in an institutional category (i.e., as members of the CHOICES 217-Like demonstration population), and who need and are receiving HCBS as an alternative to NF care. TennCare has the discretion to apply an enrollment target to this group.

(i) CHOICES Member. An individual who has been enrolled by the Bureau of TennCare into the CHOICES Program.

(j) Code of Federal Regulations (C.F.R.). Federal regulations which transfer to regulatory form the specific requirements of Federal law.

(k) Co-insurance. Coinsurance amounts payable by the recipient under the provisions of Title XVIII, Part B for covered medical services rendered under the Medicare Program and becoming due after satisfaction of the deductible liability. [42 U.S.C. §§ 1395j et seq.]

(l) Deductible. Amounts payable by the recipient which fall within an aged beneficiary's deductible liability imposed by Title XVIII, Part B. Health Insurance for the Aged. [42 U.S.C. §§ 1395j et seq.]

(m) Eligible individual. A person who has applied for medical assistance and has been found to meet all applicable conditions for eligibility pertaining to Tennessee's Medical Assistance Program.

(n) Enrollment Target. The maximum number of individuals that can be enrolled in CHOICES Group 2 at any given time, subject to exceptions defined by the Bureau of TennCare. The enrollment target is not calculated on the basis of "unduplicated participants." Vacated slots in CHOICES Group 2 may be refilled immediately, rather than being held until the next program year, as is required in the HCBS waiver programs.

(o) Excess income. That portion of the income of the individual or family group, which exceeds amounts allowable to the individual or family group as disregarded income or income protected for basic maintenance and which results in a determination of ineligibility.

1. Excess Resources. That portion of the liquid assets or other resources of the individual or family group in excess of the amounts which may be retained for the individual or family group's security and personal use, not exempted from consideration or otherwise accounted for by special specified circumstances, and which result in a determination of ineligibility.

2. Spenddown. The process by which excess income is utilized for recognized medical expenses and which, when depleted, results in a determination of eligibility if all other eligibility factors are met.

(p) Families First (FF). Tennessee's TANF program (Temporary Assistance for Needy Families) which provides cash assistance to families with dependent children. [42 U.S.C. §§ 601 et seq.]

(q) Inpatient services. Those services rendered for any acute or chronic condition, including maternal and mental health care, which cannot be rendered on an outpatient basis.

(r) Joint Custody. Legal custody of a child held simultaneously by two (2) or more caretaker relatives. The caretaker relatives must exercise care and control of the child.

(s) Level 1 Nursing Facility care. The level of Medicaid reimbursement provided for nursing facility services delivered to residents eligible for Medicaid-reimbursement of NF services determined by TennCare to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(4) by a NF that meets the requirements set forth in Rule 1200-13-01-.03, and in accordance with the reimbursement methodology for Level 1 NF Care set forth in Rule 1200-13-01-.03.

(t) Level 2 Nursing Facility care. The level of Medicaid reimbursement provided for nursing facility services delivered to residents eligible for Medicaid-reimbursement of NF services determined by TennCare to meet the medical eligibility criteria set forth in Rule 1200-13-01-.10(5) by a NF that meets the requirements set forth in Rule 1200-13-01-.03, and in accordance with the reimbursement methodology for Level 2 NF Care set forth in Rule 1200-13-01-.03.

(u) Long-Term Care Program. One of the programs offering long-term care services to individuals enrolled in TennCare. Long-Term Care Programs include institutional programs (NFs and ICFs/MR), as well as HCBS offered either through the CHOICES Program or through a section 1915(c) HCBS waiver program.

(v) Medicaid. The State program of medical assistance as administered by the Department in compliance with Title XIX of the Social Security Act [42 U.S.C. §§ 1396 et seq.] and which is designed to provide for the medical care needs of Tennessee's medically indigent citizenry.

(w) Medical assistance drug list. A listing of drugs covered under the Medical Assistance Program, which includes the drug code, description, dosage strength, covered unit form, maximum dosage covered, and per unit price.

(x) Medically Needy. Individuals whose income or resources are under a certain limit and allows them to qualify for Medicaid by spending down their medical expenses.

(y) Medicare. The Federal program under Title XVIII of the Social Security Act [42 U.S.C. §§ 1395 et seq.] providing medical benefits to persons receiving Social Security Retirement payments or who have received Social Security benefits based on disability for a period of twenty-four (24) consecutive months.

1. Part A of Title XVIII. Hospital Insurance Benefits provides hospital care, nursing home care, and home health visits, subject to deductibles and co-insurance. [42 U.S.C. § 1395c]

2. Part B of Title XVIII. Supplementary Medical Insurance provides additional medical benefits to those persons eligible for Part A or any person sixty-five (65) years of age, but only if enrolled in the program and paying the monthly premium. [42 U.S.C. § 1395j]

(z) Medicare Savings Program. The mechanisms by which low-income Medicare beneficiaries can get assistance from Medicaid in paying for their Medicare premiums, deductibles, and/or coinsurance. These programs include the Qualified Medicare Beneficiary (QMB) program, the Specified Low Income Medicare Beneficiary (SLMB) program, and the Qualified Individual (QI) program.

(aa) Nursing Facility (NF). A Medicaid-certified NF approved by the Bureau of TennCare.

(bb) Outpatient services. Services provided, in other than inpatient circumstances, for any condition detrimental to the individual recipient's physical or mental health which cannot be taken care of in the home situation.

(cc) Patient Liability. The amount determined by DHS which a Medicaid Eligible is required to pay for covered services provided by a NF, an ICF/MR, an HCBS waiver program, or the CHOICES Program.

(dd) Program of All-Inclusive Care for the Elderly (PACE). A program for dually eligible enrollees in need of long-term care services that is authorized under the Medicaid State Plan, Attachment 3.1-A, #26.

(ee) Poverty Groups. Assistance groups whose gross income does not exceed various percentages of the Federal Poverty Level Income Standard.

(ff) Qualified Disabled and Working Individual (QDWI). A person who is under age sixty-five (65) who has lost their Medicare Part A coverage because they returned to work, despite their disability, and have an option to purchase Medicare Part A for an indefinite period and for whom Medicaid pays the Medicare Part A, if income is not more than two hundred percent (200%) of the federal poverty level and resources are not more than twice the SSI limit ($4,000 for an individual, $6,000 for a couple) and is not otherwise eligible for Medicaid.

(gg) Qualified Long Term Care Insurance Policy. A long term care insurance policy issued on or after October 1, 2008, that has been pre-certified by the Tennessee Department of Commerce and Insurance pursuant to State Rule 0780-01-61 as:

1. A policy that meets all applicable Tennessee Long Term Care Partnership requirements; or

2. A policy that has been issued in another Partnership state and which is covered under a reciprocal agreement between such other state and the State of Tennessee.

(hh) Qualified Medicare Beneficiary (QMB). A person who is eligible for Medicare Part A and for whom Medicaid pays the Medicare premium, coinsurance and deductible for Medicare covered services and whose income is not more than one hundred percent (100%) of the federal poverty level and resources are not more than twice the SSI resource limit ($4,000 for an individual and $6,000 for a couple).

(ii) Qualifying Individual 1 (QI1) (also referred to as a Specified Low-Income Beneficiary (SLIB)). A person who is eligible on a "first come, first served basis" for Medicaid to pay the Medicare Part B premium, if the individual is eligible to receive Part A Medicare, is not otherwise eligible for Medicaid and income is not more than one hundred thirty-five percent (135%) of the federal poverty level and resources are not more than twice the SSI resource limit ($4,000 for an individual and $6,000 for a couple).

(jj) Specified Low-Income Medicare Beneficiary (SLMB). A person who is eligible for Medicare Part A and for whom Medicaid pays Medicare Part B premiums, if income is not more than one hundred twenty percent (120%) of the federal poverty level and resources are not more than twice the SSI limit ($4,000 for an individual, $6,000 for a couple).

(kk) Statewide E/D Waiver. The Section 1915(c) HCBS Waiver project approved for Tennessee by the Centers for Medicare and Medicaid Services (CMS) to provide services to a specified number of Medicaid-eligible adults who reside in Tennessee, who are aged or have physical disabilities, and who meet the medical eligibility (or level of care) criteria for reimbursement of Level 1 NF services.

(ll) Supplemental Security Income (SSI). A federal income supplement program funded by general tax revenues and is designed to help aged, blind and disabled individuals who have little or no income. Applications for SSI benefits are filed at the Social Security office. Individuals who are eligible for SSI are automatically entitled to Medicaid. [42 U.S.C. §§ 1382 et seq.]

(mm) Temporary Assistance for Needy Families (TANF). Program which was created by the Welfare Reform Law of 1996. TANF became effective July 1996 and replaced what was then commonly known as the AFDC program. [42 U.S.C. §§ 601 et seq.]

(nn) TennCare CHOICES in Long-Term Care (called "CHOICES"). The program in which NF services for TennCare eligibles and HCBS for individuals aged sixty-five (65) and older and/or adults aged twenty-one (21) and older with physical disabilities are integrated into TennCare's managed care delivery system.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. § 1396 et seq.; and Acts 2008, Chapter 1190.

Chapter 1240-03-02
Coverage Groups Under Medicaid

Amendments

Rule 1240-03-02-.02 Coverage of the Categorically Needy, is amended by deleting paragraph (2), subparagraph (f) in its entirety and by substituting instead the following language, so that, as amended, paragraph (2), subparagraph (f) shall read as follows:

(f) Any aged, blind or disabled (AABD) individual institutionalized in a medical institution (i.e., one organized to provide medical care) or in Home and Community Based Services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) of the Social Security Act [42 U.S.C. § 1396n(c)] HCBS waiver program who has income equal to or less than three hundred percent (300%) of the SSI Federal Benefit Rate and who meet all applicable technical and financial eligibility criteria.

1. TennCare CHOICES Program has two (2) components:

(i) Nursing Facility Services.

(ii) Home and Community Based Services (HCBS) for adults who are elderly or physically disabled.

2. There are two groups in TennCare CHOICES.

(i) CHOICES Group 1. Participation in CHOICES Group 1 is limited to Medicaid enrollees of all ages who qualify for and are receiving Medicaid-reimbursed Nursing Facility services. Medicaid eligibility for long-term care services is determined by the Department of Human Services (DHS). Medical (or level of care) eligibility is determined by TennCare as specified in Rule 1200-13-01-.10. Persons in CHOICES Group 1 must be enrolled in TennCare Medicaid and qualify for Medicaid-reimbursement of long-term care services.

(ii) CHOICES Group 2. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility level of care and who qualify for TennCare either as SSI recipients or in the CHOICES 217-Like group and who need and are receiving HCBS as an alternative to NF care. Eligibility for the CHOICES 217-Like Group will be determined using the technical and financial criteria of the institutional eligibility category. TennCare has the discretion to apply an enrollment target to this group.

(I) SSI eligibles, who are determined eligible for SSI by the Social Security Administration. SSI eligibles are enrolled in TennCare Medicaid.

(II) The CHOICES 217-Like Group, as defined in Rule 1200-13-01-.02. Financial and categorical eligibility are determined by the Department of Human Services. Persons who qualify in the CHOICES 217-Like Group in accordance with Rule 1200-13-14-.02 are enrolled in TennCare Standard.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. § 1396 et seq.; and Acts 2008, Chapter 1190.

Chapter 1240-03-03
Technical and Financial Eligibility
Requirements for Medicaid

Amendments

Rule 1240-03-03-.02 Technical Eligibility Factors, is amended by deleting subparagraph (a) under paragraph (9) and by substituting the following language, so that as amended, subparagraph (a) under paragraph (9) shall read as follows:

(a) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare. The Department of Human Services (DHS) shall disregard an individual's assets up to the amount of payments made by the individual's qualifying long-term care insurance policy for services covered under the policy at the time of TennCare application.

Rule 1240-03-03-.02 Technical Eligibility Factors, is amended by deleting paragraph (10) in its entirety and by substituting the following language, so that as amended, paragraph (10) shall read as follows:

(10) Institutionalized individuals in a medical institution (i.e., one organized to provide medical care, including nursing and convalescent care) must be likely to be continuously confined for at least thirty (30) consecutive days going forward, as evidenced by an approved NF Preadmission Evaluation eligibility segment which, when combined with the days already confined, total at least 30 days, prior to attaining Medicaid eligibility based on institutionalization. Medicaid eligibility in a NF is retroactive to the later of: a) the date of admission; or b) the date of application when thirty (30) consecutive days of institutionalization is met. Coverage of Home and Community Based Services (HCBS) offered either through CHOICES Program or through a Section 1915(c) of the Social Security Act HCBS waiver program requires a determination that the individual needs, and is likely to receive, HCBS services for thirty (30) consecutive days going forward. The effective date of eligibility in an HCBS program is the date of approval by DHS.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. 1396 et seq.; Acts 2008, Chapter 1190.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, is amended at paragraph (2), subparagraph (a), part 1, subpart (i) to add the phrase "offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program" at the end of the second sentence, so that as amended, paragraph (2), subparagraph (a), part 1, subpart (i) shall read as follows:

(i) A homestead may be exempt if used as a home by the applicant/recipient, spouse, and/or dependent/relative. If absent from the home with intent to return, an individual may retain a homestead for an unlimited period of time. Based on current market values, individuals with an equity interest in their home greater than five hundred thousand dollars ($500,000) are ineligible for Medical assistance for either institutional care or Home and Community Based Services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program. Beginning in the year 2011, the five hundred thousand dollar ($500,000) limit on home equity will increase each year. The increase will be based on the percentage

increase in the Consumer Price Index (CPI) for all urban consumers, rounded to the nearest one thousand dollars ($1,000).

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, at paragraph (3), subparagraph (b) and (c) is amended by adding the phrase "offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program" in the first sentences respectively, so that as amended, paragraph (3), subparagraph (b) and (c) shall read as follows:

(b) The period of ineligibility for nursing home vendor or waivered services under HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program for assets transferred within sixty (60) months of application for long term care nursing services or HCBS will be determined by dividing the uncompensated value of the transferred asset by the average monthly nursing home private pay rate. In determining the penalty for a transfer a State may not round down or disregard any fractional period of ineligibility. There is no limit on the maximum months of ineligibility. The penalty continues until expired unless hardship is considered to exist and the institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations and the application of the penalty will result in loss of essential nursing care, which is not available from any other source.

(c) If an asset has been found to be transferred for less than fair market value within the sixty (60) month look-back period, the penalty period begins the month the individual becomes eligible for institutional care or Home and Community Based Services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program or the month of the transfer, whichever is later. The penalty period runs consecutively even if the individual leaves the nursing home for a period of time and later returns. If a penalty period is imposed for new applicants, Medicaid requires a denial notice. If a penalty period is imposed on an individual who is already receiving Medicaid, a ten (10) day adverse action notice is required.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, is amended by deleting paragraph (3), subparagraph (e), part 4, subpart (ii) and by inserting new subparts (ii) and (iii), and renumbering the current subpart (iii) as subpart (iv), so that as amended, paragraph (3), subparagraph (e), part 4, subpart (ii), (iii) and (iv) shall read as follows:

(ii) The transfer of assets will be subject to a penalty period of ineligibility for nursing home vendor payments determined by dividing uncompensated value of the transferred asset by the average monthly nursing home charge at the private pay rate unless satisfactory proof is provided that the individual intended to dispose of assets for fair market value; or assets were transferred exclusively for a purpose other than to qualify for Medicaid; or transferred assets have been returned to the individual; or it is determined that the penalty period would work an undue hardship as defined in (3)(b) above.

(iii) Transfer of an asset for individuals enrolled in HCBS either through the CHOICES Program or through Section 1915(c) of the Social Security Act negates any eligibility under 42 C.F.R. § 435.217. The penalty for HCBS waiver recipients is the non-payment for waiver services, the receipt of which is an eligibility requirement for the HCBS category. The individual would remain ineligible until the look back period had expired, or until such time as he/she entered a nursing facility. Upon entry into a nursing

facility, the penalty period would commence and continue for the appropriate period of time.

(iv) Assets include all income and resources, including the home, unless transferred as indicated in (a) above, of the institutionalized individual and his/her spouse (including income and/or resources the individual is entitled to, but does not receive because of any action by the individual or his/her spouse, or a person (including a court) or administrative body with legal authority to represent the individual, his/her spouse, or who acts at the direction or request of the individual and his/her spouse).

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, at paragraph (8), subparagraphs (a), (b) and (c) is amended by adding the phrase "offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program" in the first sentences respectively. Parts 1 and 2 under subparagraph (c), paragraph (8) are not being amended. As amended, subparagraphs (a), (b) and (c) under paragraph (8) shall read as follows:

(a) Individuals who are receiving or will receive nursing facility services or home and community based services (HCBS) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program and whose income exceeds the Medicaid Income Cap (MIC) may establish an income trust, referred to as a Qualified Income Trust (QIT) or “Miller Trust”. Funds placed in a QIT that meets the standards set forth in paragraph (8) are not treated as available resources or income for purposes of determining the individual’s TennCare eligibility.

(b) A QIT is a trust consisting only of the individual’s pension income, Social Security Income, and other monthly income that is created for the purpose of establishing income eligibility for TennCare coverage when an individual is or soon will be confined to a nursing facility, HCBS or ICF/MR waiver program offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program.

(c) An individual is eligible to establish a QIT if his or her income is above the level at which he or she would be financially eligible for nursing facility, HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program, or ICF/MR care under Medicaid.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. 1396 et seq.; Acts 2008, Chapter 1190.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, is amended by deleting paragraph (8), subparagraph (d), part 2, subpart (i) in the entirety and by substituting the following language, so that as amended, paragraph (8), subparagraph (d), part 2, subpart (i) shall read as follows:

(i) A personal needs allowance up to the amount recognized under Tennessee Medicaid policies. As of January 1, 2010, this amount is Fifty Dollars ($50) per month;

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, T.C.A. § 71-5-147; 42 U.S.C. § 1396a(q); and Acts 2009, Chapter 592, § 1.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, at paragraph (8), subparagraph (d), parts 3 and 4 is amended by adding the phrase "offered either through the

CHOICES Program or through a Section 1915(c) HCBS waiver program" in the first and second sentences respectively, so that as amended, paragraph (8), subparagraph (d), parts 3 and 4 shall read as follows:

3. Each month the Trustee shall distribute the entire amount of income remaining in the trust after any disbursements made under Part 2 above to the State of Tennessee, Bureau of TennCare (or directly to the nursing facility or HCBS provider or Managed Care Organization (MCO) offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program, as directed by the Bureau of TennCare), up to the total amount of expenditures for medical assistance for the Grantor.

4. The sole beneficiaries of the trust are the Grantor for whose benefit the trust is established and the State of Tennessee (Bureau of TennCare). The trust terminates upon the death of the Grantor, or if the trust is no longer required to establish Medicaid eligibility in the State of Tennessee, if nursing facility or HCBS offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program is no longer medically necessary for the Grantor, or if the Grantor is no longer receiving such services.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. 1396 et seq.; Acts 2008, Chapter 1190.

Rule 1240-03-03-.03 Resource Limitations for Categorically Needy, is amended by deleting paragraph (9), subparagraph (b), part 1 to insert new figures, so that as amended, paragraph (9) subparagraph (b) part 1 shall read as follows:

1. Effective April 1, 2009 one-half (1/2) of the total resources owned by both spouses not to be less than twenty-one thousand nine hundred twelve dollars ($21,912) nor greater than one hundred nine thousand five hundred sixty dollars ($109,560) and adjusted annually per federal law;

Authority: T.C.A. §§ 4-5-201 et seq.; 4-5-202, and 4-5-208; and 42 U.S.C. § 1396r-5.

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy, is amended by deleting subparagraph (a) under paragraph (2) in the entirety and by substituting instead the following language, so that as amended, paragraph (2), subparagraph (a) shall read as follows:

(a) Any aged, blind or disabled individual confined to long term nursing care in a facility must be likely to be continuously confined for at least thirty (30) consecutive days, as evidenced by an approved NF Preadmission Evaluation eligibility segment which, when combined with the days already confined, total at least 30 days, prior to attaining Medicaid eligibility or if enrolled in a HCBS waiver program offered either through the CHOICES Program or through a Section 1915(c) HCBS waiver program and likely to receive HCBS services for at least 30 consecutive days going forward, may have countable income equal to or less than 300% of the SSI/FBR beginning the month of admission.

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy, is amended by deleting subparagraph (b) part 1 under paragraph (2) and by substituting the following language, so that as amended, paragraph (2), subparagraph (b), part 1 shall read as follows:

(b) The otherwise eligible individual confined to a long-term care facility is required to assume some of his/her cost of care.

1. Personal Needs Allowance: $50 for an individual. The personal needs allowance for each person receiving Medicaid in a Nursing Facility or an Intermediate Care Facility for persons with Mental Retardation is $50.

(i) The maximum personal needs allowance for persons participating in CHOICES Group 2 is 300% of the SSI Federal Benefit Rate.

(ii) The maximum personal needs allowance for persons participating in one of the State's Section 1915(c) HCBS waivers is as follows:

(I) The Statewide HCBS E/D Waiver: 200% of the SSI Federal Benefit Rate.

(II) The Statewide MR Waiver: 200% of the SSI Federal Benefit Rate.

(III) The Arlington MR Waiver: 200% of the SSI Federal Benefit Rate.

(IV) The Self-Determination MR Waiver: 300% of the SSI Federal Benefit Rate.

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy, is amended to insert new figures in part 2 under paragraph (2), subparagraph (b). Subparts (i) through (iii) under part 2 under subparagraph (b) paragraph (2) are not being amended and will remain as they currently exist. As amended, part 2, under subparagraph (b) paragraph (2) shall read as follows:

2. Effective April 1, 2009, spousal dependent allocation not to exceed two thousand seven hundred thirty-nine dollars ($2,739) per family, and adjusted annually per federal law, which includes:

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy, is amended by deleting subparagraph (d) part 1 only, under paragraph (2). Parts 2 through 5 under subparagraph (d) of paragraph (2) are not being amended. As amended, paragraph (2), subparagraph (d), part 1 shall read as follows:

(d)

1. Personal Needs Allowance: $50 for an individual.

Rule 1240-03-03-.04 Income Limitations for the Categorically Needy is amended by deleting paragraph (3) only and inserting a new paragraph (3). Subparagraphs (a) through (c) under paragraph (3) are not being amended. As amended, paragraph (3) shall read as follows:

(3) Post-eligibility treatment of income for individuals participating in Home and Community Based Services (HCBS) offered either through CHOICES Program or through a Section 1915(c) of the Social Security Act HCBS waiver program will be determined as follows:

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-208, 71-1-105(12), 71-5-101, 71-5-103, 71-5-111 and T.C.A. §§ 71-5-1401 et seq.; 42 U.S.C. § 1396 et seq.; 42 U.S.C. § 1396a(q) and 42 U.S.C. § 1396r-5; and Acts 2008, Chapter 1190.

I certify that this is an accurate and complete copy of an emergency rule(s), lawfully promulgated and adopted.

Date: _____

Signature: _____

Name of Officer: Phyllis Simpson

Title of Officer: Assistant General Counsel
Tennessee Department of Human Services

Subscribed and sworn to before me on: _____

Notary Public Signature: _____

My commission expires on: _____

All emergency rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

_____
Robert E. Cooper, Jr.
Attorney General and Reporter

_____
Date

Department of State Use Only

Filed with the Department of State on: _____

Effective for: _____ **days*

Effective through: _____

** Emergency rule(s) may be effective for up to 180 days from the date of filing.*

_____
Tre Hargett
Secretary of State

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to TCA 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules are being promulgated so that the TennCare Medicaid rules do not conflict with the TennCare CHOICES program.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rule chapter is lawfully promulgated and adopted by the Department of Human Services in accordance with T.C.A. §§ 4-5-208 and 71-5-105.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The governmental entity most directly affected by this rule is the Tennessee Department of Finance and Administration.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The rule was approved by the Tennessee Attorney General. No additional opinion was given or requested.

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

The promulgation of this rule chapter is not anticipated to have an effect on state and local government revenues and expenditures.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Marcia Garner, Director, DHS Medicaid/TennCare Policy Marla Taylor, Program Manager, DHS Medicaid/TennCare Policy

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Marcia Garner, Director, DHS Medicaid/TennCare Policy Marla Taylor, Program Manager, DHS Medicaid/TennCare Policy Phyllis Simpson, Assistant General Counsel, DHS

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Marcia Garner, Citizens Plaza Bldg, 12th Floor, Nashville, TN 37243 (615) 313-5465 Marcia.Garner@tn.gov Marla Taylor, Citizens Plaza Bldg., 12th Floor, Nashville, TN 37243 (615) 313-4873 Marla.Taylor@tn.gov Phyllis Simpson, Citizens Plaza Bldg., 15th Floor, Nashville, TN 37243 (615) 313-2269 Phyllis.Simpson@tn.gov

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

NONE